MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

CHARTING – RULES TO OBSERVE

Effective Date: September 1, 2002 **Policy #:** HI-03

I. PURPOSE: To provide general rules for charting that will assist personnel in correctly transcribing information to the staff progress notes, nurses notes, graphic sheets, and nursing activity flow sheets.

II. POLICY: The medical record is a written legal record of the patient's hospitalization from admission to discharge, is a permanent part of the hospital records, and should be accurate, complete, legible, concise and neat.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. All Clinical Staff documenting in patient record are required to follow charting rules.

V. PROCEDURE:

A. Charting Rules:

1. All documentation will be completed in black ink.

2. Capitalize, punctuate, and spell correctly.

3. Only standard accepted abbreviations may be used - Refer to policy: Abbreviations.

4. All entries must be neat and legible.

5. The person recording must write signature consisting of first initial, full last name, and title. When recording during a specified time, i.e., one shift, one signature is sufficient.

6. Signature should follow last recorded sentence, should be placed on same line as last entry, and underlined on Nurses' Notes.

7. Charting continued on a new page: Bottom of page requires signature and "continued" or "cont" stated. The next page requires new heading including "continued" or "cont."

8. Record information in the proper column, on the correct form of the correct chart.

9. Use adequate space for wording: Do not leave any blank lines or columns.

10. Never erase or obliterate an error. Errors are marked by crossing through words with one horizontal line, marked error, and initialed.

11. If it is necessary to copy a page, the original should be retained with the copied sheet and marked with a large X across face. The copied sheet should be marked "recopied" across the top and properly signed and dated.

12. If quoting the patient, state exact words and place in quotation marks.

13. Ditto marks are not to be used in charting.

14. Record after an intervention has taken place, not before.

15. Keep record intact. Do not remove documents from the record for charting purposes.

B. Observations:

1. All pertinent subjective and objective information should be recorded accurately and as soon as possible.

2. The person caring for the patient is responsible for documenting their own observations and care/interventions provided.

3. Describe any response that is not customary for that patient.

4. Record positive as well as negative behaviors.

5. Use simple, descriptive terms which can be understood by all care givers.

6. Do not document another patients' behaviors in this patient's medical record (unless necessary to explain what the patient is responding to). Do not document another patient's name in this patients medical records.

7. It is not necessary to quote profane or obscene words when documenting.

VI. REFERENCES: CMS Condition of Participation 482.24 C(l) C (1i)

VII. COLLABORATED WITH: Director of Nursing Services, Director of Treatment and Rehabilitation, Medical Director, Director of Information Resources

VIII. RESCISSIONS: #HI-03, *Charting – Rules to Observe* dated February 14, 2000; HOPP #13-05C.R. 012479, *Charting – Rules to Observe*, May 1983

IX. DISTRIBUTION: All hospital policy manuals.

X. REVIEW AND REISSUE DATE: September 2005

XI. FOLLOW-UP RESPONSIBILITY: Director of Information Resources

XII. ATTACHMENTS: None

_____/___/__		_____/___/__	
Ed Amberg	Date	Thomas Gray, MD	Date
Hospital Administrator		Medical Director	